William Arndt, MA, LMFT, LADC
Licensed Marriage and Family Therapist
Licensed Alcohol and Drug Counselor

Release Of Information

I, _____, authorize William Arndt, MA, MFT, LADC to disclose the information initialed below TO and/or FROM _____.
(Person or agency to which disclosure to be made

Purpose of disclosure:

_____Diagnosis

_____Treatment Plan

_____Assessment

_____Progress Notes/Interventions

_____Discharge Summary/Status

_____Case Management

_____Payment

_____Other (specify):_____

I understand that my records are protected under federal regulations and Nevada statutes and administrative regulations and any further discloser is prohibited without the consent of the undersigned. I also understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance to it. I understand that this authorization will automatically expire twelve (12) months after date signed.

I further release William Arndt, MA, MFT, LADC from any liability arising from the release of information to the person/agency designated above. I acknowledge that the information to be released was fully explained to me and this consent is given of my free will.

_____
Client Signature Date

_____
Client Signature Date

_____
William Arndt, MA, MFT, LADC Date